Quality Measures Workgroup
Draft Transcript
January 28, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, operator. Good afternoon, everybody, and welcome to the Policy Committee's Quality Measures Workgroup. This is a two hour call. It's a Federal Advisory Committee call, so there will be opportunity at the end of the call for the public to make comments. Let me do a quick roll call. David Blumenthal?

David Blumenthal – Department of HHS – National Coordinator for Health IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman? Eva Powell?

Eva Powell – National Partnership for Women & Families – Director IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Marc Overhage? Carol Diamond?

Carol Diamond – Markle Foundation – Managing Director Healthcare Program
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Peter Basch?

Peter Basch – MedStar Health – Medical Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bob Kocher? Jacob Reider?

Jacob Reider – Allscripts – Chief Medical Informatics Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Karen Kmetik? Jesse Singer? Tim Ferris?

Sarah Scholle – NCQA – Assistant Vice President, Research
Hello?

Judy Sparrow – Office of the National Coordinator – Executive Director
Who's that, Karen?

Sarah Scholle – NCQA – Assistant Vice President, Research
This is Sarah Scholle.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay. Jesse Singer? Tim Ferris? Laura Petersen? Jim Walker? Cary Sennett?

Cary Sennett – MedAssurant – Chief Medical Officer
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul Wallace? Taylor Clark? Janet Corrigan, in for Helen Burstin. David Kendrick? Patrick Gordon? Sarah Scholle, I know she's on.

Sarah Scholle – NCQA – Assistant Vice President, Research
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Russ Branzell? Tripp Bradd? Charles Kennedy? Norma Lang?

Norma Lang – University of Wisconsin and American Nurses Association
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Terry Cullen? Jon White?

Jon White AHRQ/HHS – Director IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Shelly-Ann Sinclair, CMS? Frances Cotter, SAMHSA?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Tom Sang?

Tom Sang – ONC
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Josh Seidman?

Josh Seidman – ONC
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anybody off?

Ahmed Calvo – DHHS/HRSA – Senior Medical Officer
Ahmed Calvo, HRSA.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Daniel Green – CMS/HHS – Medical Director
Dan Green, CMS.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Pat Santora – SAMHSA/CSAT
Pat Santora, SAMHSA.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. All right, with that I'll turn it over to Dr. David Blumenthal.

David Blumenthal – Department of HHS – National Coordinator for Health IT
Thank you, Judy. Thanks to all of you who are able to make it. I expect there will be others joining. Just some very brief introductory comments. The request for information you will hear more about in a moment, it's elicited a huge response from the community and that's something we're extremely pleased and grateful for. As always, the public has been very, not only supportive but creative in bringing ideas before us, ONC and our advisory committee, so a lot of this meeting is going to be about exactly what was found in the comments and what we've concluded from them and what we plan to do going forward. I think during the course of these meetings, since we began this of course the department has published a national quality strategy and work continues on accountable care organization regulations, on bundled payments, on a whole series of innovations that I think are going to be coming, or innovative approaches are going to be coming out of the department. So the work that this committee is doing I hope will channel in, as we said before, channel into a much broader stream of work beyond the Meaningful Use framework. But it is chiefly the Meaningful Use framework that we can directly impact.

Meaningful Use is being implemented, we have 14,500 registrations initiated under the Meaningful Use program so far, so that's three weeks worth of registrations, and so that's an encouraging development and it's now real. We are of course already thinking about stages two and three, to which this work is most relevant. So I'm going to listen carefully and get educated with the rest of you about what's been learned from public comments and just thank you again for participating and thank David Lansky especially for his shepherding of this process.

David Lansky – Pacific Business Group on Health – President & CEO
Thank you, Dr. Blumenthal. Obviously, we appreciate the overall strategy and leadership you're giving us, and we're trying to do our part here. Let me give you a quick overview to the committee as a whole, where we are at the moment and then what we're going to try to do today, and I'm looking toward next week and beyond, so first, let me start with an enormous thank you to the staff. There's a number of staff people who have been working literally day and night and all weekend to try to assimilate all the feedback we got from the public, and we really owe them a debt of gratitude for their commitment to helping us get to this point. At the same time we are working as fast as we can against deadlines, and so I think we're all prepped to try to absorb the information and make some good decisions to be consistent with the timeline we're trying to operate on per getting stage two out the door.

Our charge today, the staff has done really heroic work to compress about 1,100 submitted measures and measure content into something we can begin to wrap our hands and heads around. We're trying hard not to preempt ... for our committee and the Tiger Teams to do their work in assessing what the

submitted material and how well it achieves the goals of the committee. At the same time, we're trying to find a way to be a little more efficient than having us look through 1,100 measures, so what we've done in the last week is take the large set of submissions, first crunch them down to about 490 unduplicated ideas or measures, which is a little more tractable, and then do one first half through and say which of these are well enough documented, discrete enough, and responsive to the criteria that the Tiger Teams developed so we should take a more serious look at them, and that took us down to about 106 measures which are still worthy of clear consideration and there's certainly the other measures in the balance that we aren't in 106, but we wanted to bring back in. So we're going to be asking the Tiger Teams to give us a look at the stuff that we've put aside and make sure we haven't missed anything important.

But for the sake of our discussion we're going to pretty much confine our attention to the smaller group, which is about 106, and we're not obviously even then going to try to go through 106 measures today and have a discussion about them. So the continuing splitting of the difference we're trying now is to walk through each of the major domains that we have talked about and have the staff report to us on where they think the submissions are responsive and were in reasonably good shape to get to the desired outcome, which is a Meaningful Use reportable quality measure, either in stage two or stage three, and where the staff is able to give us their thinking on qualifying measures or measure concepts are we close enough that we could go out to the field and solicit some additional developmental work in the next nine to twelve months that would get us to the goal.

So we're going to actually take today the distillation of the submitted material from the public comments and we're going to, on this call, talk about do we have enough material in some of these measure concepts to encourage ONC and CMS to go out with some funding to try to get finalized specifications or guidance from the measurement field during this 2011 period. Let's see if I said that adequately. Now what we're going to do after today's discussion and hopefully elicit from all of you some prioritization and sense of direction, you've charged the Tiger Teams over the next two weeks or so with taking the input from this call, the input from the staff and the raw material from the public comments and vetting all that and coming back to us with their best thinking of where ONC should go from here with further development work, so today is essentially a guidance call. One other piece that's germane is of course next week there's an HIT Policy Committee meeting where we need to report an update of our progress. So hopefully at least I'll be listening to today's call to see what we're ready to report to the general Policy Committee about our progress to date.

Let me pause at that point and ask Tom or Josh if they have any other setup comments about where we are in the process.

Josh Seidman – ONC
I think that's great.

David Lansky – Pacific Business Group on Health – President & CEO
Tom, anything else?

Tom Sang – ONC
No. I think the only thing logistically we have to decide is a time for next week or the week after for the Tiger Teams to have their two hour discussion. So we can do that through e-mail.

David Lansky – Pacific Business Group on Health – President & CEO
You mean each of the teams have their own discussion?

Tom Sang – ONC
Yes.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, we'll do that off line. But hopefully all of you on the call who are interested in being in the Tiger Team need to make sure you're alert to scheduling as soon as we can in the next ten days or so those more detailed calls in each domain area.

So with that, let's go to the slide deck. Let me just explain what's in your zip file that you received last night, and again our apologies for the lateness of trying to get material to you. You have a slide deck which we'll go through fairly briefly today, and that's more of a trigger to the staff to give us their input. You have the spreadsheet called collect measures list, which is the 106 or so, at least last time I looked, and "Select QMWGRC Measures." That has 106 or so rows which are the ... staff suggested measures for further consideration. We've also given you the full download list of the entire submission so you can certainly go back and reference anything there for more detail or you think we missed something in the distillation. Then you've got a summary report that was submitted about the overall selected comments that the consulting firm had compiled some of this and provided it to ONC so you could see the full roster of additional comments and perspectives. At the end of this call, I do want to come back to some other issues that are not specifically about these measures, including the methodology questions and some of the others, for example, specialty measures and the retooled measures which are still in our portfolio but won't be the primary subject today. We'll come back to that at the end of this call.

So with that, let's go to the slides and see if we have that teed up on the Webinar. The "Total Respondent" slide you have in front of you, I hope. We had 134 respondents, mostly organizations naturally. The next two slides, I think, list the organizations that responded to our request. It's a great list of prominent associations, delivery systems, research organizations, consumer organizations, industry sectors, so the good news is people are paying attention and we got a lot great feedback, as David said, and we have an opportunity to really digest the nation's wisdom as we go through the process now. I think a lot of people are seeing this as the leading edge of the broader measurement challenge that CMS will face and ... will face and everything else, so in some sense this 1,000 measures we've got gives us kind of an inventory of measurement thinking out there which hopefully a lot of both federal and private endeavors consider as they look at new measures. So in one sense not only do we want to certainly serve our immediate master and make sure that the Meaningful Use process has the benefit of this input, but you certainly should keep your eyes on these materials and consider how other processes that may be involved in it can take advantage of some of this material, and certainly these organizations are great collaborators with all of us.

The next slide takes us into the depths of our discussion today, so we have the five domains. What we asked the staff to do is just to summarize against the measure concepts that the Tiger Teams had identified what kind of response did we get, so you get the number of responses, the number of measures, and then the number of filtered or selective measures in the green that the staff had recommended we give additional consideration to. You'll understand that a lot of the proposed measures and measure concepts fit multiple categories, so don't try to do unduplicated counting off these slides.

So with that, I don't know, I'll see if Josh is able to give us a summary of the patient and family engagement material that we got and maybe Josh in addition talk a little bit about the data collection platform question that I know arises in this domain.

Tom Sang – ONC
Sure. Thanks, David. Clearly, we've got a lot of great ideas. Some of these are ideas, some are validated instruments and some of them are somewhere in between. There are about 35 measures that are in what David described as ... and they do cross over the range, I would say, with the primary exception of the last category, which is patient access to community resources for improved and sustainable care coordination, so there's that area. Then the area of honoring patient preferences, shared decision making, particularly the area of shared decision making we had actually put experience of care in that, so there certainly are some things there. But there are some measures that have been proposed around measures of decision quality for preference sensitive conditions, and certainly those have a lot of potential. They're probably not in a state of readiness that they would be ready for stage two, so that's why that is listed in the gap areas as well.

There are a series of methodological issues that we need to work on, three of them in particular. In many cases there are some validated instruments for which there may be a lot of good measures, but we may very well need to think about how to distill that instrument into specific measures of items that we really think about for reporting of clinical ....

The second issue is how data will get into the electronic health record, so specifically thinking about how that data will enter. So what are the different modes of entry, whether that be through portals, through ..., through other mechanisms, and could it be entered by other people using more traditional modes of administration, and how does that fit in with some of our other goals? If you're not on mute, it would be helpful to .... The ... there relate in part to the question of when data are being integrated into the EHR, do we want the data to come necessarily from all patients, or do we want to still be doing some sort of sampling approach and that would be a methodological issue that would potentially cross all patient reported measures.

So just to describe a little bit some of the main measures that are closest to readiness, first, there's the CAHPS measures, which primarily are around experience of care, but there are different CAHPS instruments in the whole sort of CAHPS family. So the traditional ones related to hospital, clinical, and group CAHPS, the patient's in a medical home and so forth, are really around those issues around patient experience with their care. There's also the CAHPS health IT instrument, which actually gets at patients' experience in using patient facing health IT. So that is, to some extent, the patient assessment of some of the things that are in the current Meaningful Use functional measures. So are they able to access information in a timely way? Are they able to communicate effectively with their clinicians and with the ...?

There are some measures that get at health risk and functional status, and so there are a series of measures that are validated instruments, the promise instruments, various things that have evolved out of the SS36 work, things that related to that. And then there are a series of other potential, and again in something like the promise instruments there are a wide range of items, so there still would need to be a lot of distilling in order to get down to specific measures. Then finally I think that there are some additional measures, things related to patient activation and self-management, where there may be some questions about how much to include and how far down to go in terms of what kinds of instruments would be required of providers. So let me pause there, David. I know you may want to add some things.

David Lansky – Pacific Business Group on Health – President & CEO
Josh, you summarized the category of the sub-domains and the available instruments that we got some recommendations from. If you were out there saying what do we need to do to get this over the goal line for stage two, what's your sense from the responses or what's realistic to aspire to? Or is this a stage three thing? What remains to be done to get to the end game?

Josh Seidman – ONC
I think that there are a series of things, methodological and operational issues that relate to the issue of patient reporting measurement, so the issue of census versus sampling, the issue of how the data enter the EHR, and how we think about large survey instruments and getting them into specific measures. I think some of those things can be addressed, we might want to think about a series of methodological questions related to patient reporting measurement that could be addressed overall, and then we might think of a separate set of issues that might be related to the issues around specific instruments. Actually, I would just say one other thing, that the expectation for how data would come in will also have important implications for what is expected in the Meaningful Use criteria and in the standards that would need to be developed for stage two as well.

David Lansky – Pacific Business Group on Health – President & CEO
That's interesting. So on the measures themselves front, your sense is we've got submitted to us a good number of measures and data and item sets, which are responsive to domains the Tiger Team identified, and while there is some work to select to refine or pick, and on that front our primary challenge will be on the method and operational side.

Josh Seidman – ONC

Yes.

David Lansky – Pacific Business Group on Health – President & CEO
Okay. So let me just open it up for questions and comments and reactions.

Christine Bechtel – National Partnership for Women & Families – VP
It's Christine. Hi, everybody. I guess my question is, it would make sense that there could be some potential investments to resolve some of the reporting and methods issued by stage three. But for stage two it seems that since we do have a number of measures that are probably ready for primetime but we may not be able to work through the direct entry into EHR, I'm wondering what the options are with respect to either attestation or summary data reporting in the way that other quality measures are reported. I think what is underlying my question is, how is it that we make sure that we advance quality measurement and patient and family engagement in that domain in the same way that we're advancing that kind of measurement in other areas, but do so in a way that recognizes the challenges and yet actually drives some advancement in the near term, at least in using the EHR to improve patient and family engagement. So I'll restate my question, what are our options for stage two collection and reporting for things where the measure's ready for primetime but maybe the method isn't?

David Lansky – Pacific Business Group on Health – President & CEO
If I can react, because I like the question a lot. I do think this may be a good thing to give out to a contractor. One reaction I have, just top of mind, is you can imagine, for example, if we go down the route of expecting third party data collection, like we do with CAHPS and other patient based surveys, rather than having each doctor conduct their own survey or commission their own survey, you could imagine the requirement from a functional point of view is to collect e-mail addresses of the sample of patients or all patients and be capable of exporting that e-mail address list to the business associate who's responsible for conducting the survey, and that's the functional obligation of this stage and the data collection itself happens through the third party. But something like that, there's an allocation of roles, I guess, it would have to have some vendor help us think about.

Tom Sang – ONC
David, I also want to add that in the blog site and letter comments, we've received several comments from major organizations, including AHA, about if there are HCAHPS survey-like instruments that they would prefer not to have the survey comments go directly into the EHR, not into the patient's medical record when it's a survey about their providers or the experiences with their providers.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Tom. Other comments or reactions to this?

W
Let me add to, David, what you said, which makes sense in the case of CAHPS, but I'm also thinking, and I'm going to pick one that in the brief time I've had to look at this, if you were to look at a measure of patient self-management there's the Medicare Health Outcomes Survey, or let's say if it's activation there's the PAM survey, there's a bunch of different assessment tools that are in fact ready to go. Is it possible to think of those tools in a way that we think of other quality measures, so that in the same way that a provider is reporting lipid control and aggregate level as part of Meaningful Use already, they're reporting the functional status measure at the aggregate level even though we don't have all the methodology for the linkage back into the EHR to be working in stage two.

David Lansky – Pacific Business Group on Health – President & CEO
Other discussion around that?

Jon White AHRQ/HHS – Director IT
David, it's Jon White. I'm going to make this comment once and it's going to apply to all the other categories as we go through them, but once will suffice. I hope that as we take all this great work, and I really appreciate all the effort that went into getting this together, and in our separate Tiger Teams try to drill down on these and try to come to a ... set, I really hope that one of the filters that we've applied to

these are which of these suggestions add value to the providers that we are incenting through ... to drive this. I'm thinking here as Jon White, family doctor, but what information am I going to want in a timely way which health IT should enable, that makes a difference for me as a practice and are things I feel like I can act on. So, enough said. Thank you.

Josh Seidman – ONC
Jon, this is Josh again. I think that relates to something that Tom was saying before, when the data is coming in that relates to something like what was your experience with this provider, I think that that is data that, again, overall in the aggregate can be useful, but it only needs to be an aggregate to the practice. And so it doesn't need to be, to Tom's point, having to be anonymous makes sense. In some cases the data, let's say functional status, would be something that in particular, to a particular patient would be of use and we certainly heard this from other people, that they would want that data to be integrated into the EHR. So it depends upon the type of data that we're getting in the patient report whether we would want it into the EHR or not.

Peter Basch – MedStar Health – Medical Director
This is Peter. I would concur completely with that last comment.

Sarah Scholle – NCQA – Assistant Vice President, Research
This is Sarah Scholle. I agree with Christine and others that this information on functional status and patient activation, that can help to define a care plan. So I like the idea of this. One of the issues may be how that information is in the EHR so that you can do a survey on paper and then somebody puts the information or a score in the EMR and that may be the way it happens now. So I'd like to think through that process and what counts as being in the EMR.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is Paul, David.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, Paul, go ahead.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm trying to put together some of these recent comments. I guess there are a couple of dimensions to the patient centered information. One is the experience of care, which affects the relationship between the patient and the provider. I think both of the things I'm going to mention affect quality, to the extent that we can involve the patient engagement and the patient experience into the quality measure per se is useful. So the one dimension is how my ability to have a good relationship with the patient is not because it's only their "satisfaction" but because it contributes to their care. The second piece is how I use individual information about how people are doing, let's say PAM, the patient activation measure, that affects their adherence to a treatment plan and to understanding, etc. That also directly impacts the quality of the care rendered and the outcome. I think both of those, we want to make sure that we keep this really embedded in the care health promotion side and quality level in a ... experience. I'm not sure I articulated that correctly, but it's sort of adding to what people said.

David Lansky – Pacific Business Group on Health – President & CEO
This is David again. I would compound against that by saying there is, to Jon's original point, both goals are worthy of our intention, that is the feedback to clinicians to improve care, either individual personal care or performance levels that help them improve their aggregate care to their panel. And, secondly, Congress, in developing the program, expected there to be performance information made available about quality performance, as in PQRI and other programs, so this is meant to be, I think, an infrastructure that will produce quality measures even apart from their value in informing provider improvement specifically. I think they're both goals we have to keep in mind.

Peter Basch – MedStar Health – Medical Director

This is Peter Basch. I have one other comment. Is there a thought given in the actual choice of measures and further measure development as to broad applicability of the measure across multiple specialties versus things that appear to be focused more towards particular specialties? Because clearly I think there are some that are more broadly applicable and others that one might look at as being more applicable to, let's say, providers who deal with chronic illness.

David Lansky – Pacific Business Group on Health – President & CEO
My answer to that is I'm going to ask that our workgroup take up that question in more detail in March and April. I think the question of the whole specialty specific quality reporting strategy, which as you know in phase one individual specialties were given a menu to choose from and so on, and I think we need to at least talk that through and see if that's the right approach to advocate to recommend going forward. If you look at the roster of 100 measures, a very large percentage of them were specific to specialties and not easily generalized, either across conditions or across reporting specialties. So I think that we've all had desire to have an elegant economy of measurement and we would find a small number of measures, which we used to call core measures, that would cut across specialties, and I think that's still the bias. I think we know that there are some limits to how comprehensive we can be with that approach, so my take is we need to really tackle that question earnestly after we get through this first half to review it. But let me see if Josh or Dr. Blumenthal has another thought on that.

Josh Seidman – ONC
No, I think that's right.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
This is Karen Kmetik. Can I offer one point on this one?

David Lansky – Pacific Business Group on Health – President & CEO
Sure, Karen.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Hi. I'm just thinking out loud here. I'm wondering also maybe in the stage two realm, as I know we're trying to get on a trajectory so that with each stage we get closer to our end goal, and I'm just wondering if there's any opportunity in phase two about connecting some of this interest in patient engagement with the next category of appropriateness. I'm thinking out loud, for example, like back pain and PCI and, for example, we're looking at a measure, assessment of a patient's knowledge regarding the benefits and risks of PCI and I don't know, I don't want to get us off the trajectory of having, as you said, David, some overarching measures and methodology that's going to get us to being able to measure patient and family engagement all the time, but I'm just wondering if for stage two there are some that we could link with other concepts that would get us in that direction.

Tom Sang – ONC
Karen, this is Tom. I think that that's a really good suggestion. We haven't really talked about composite measures and that's something to really think about, at least I don't want to get into the clinical appropriateness measures yet, but one of the suggestions was really creating a clinical quality dashboard that would be a multiple set of measures and with that specific example of the lower back pain, I guess not only can you do functional status measures for someone with lower back pain, but you can also then look at patient activation measures as well as embed something like an overuse efficiency measure of whether they've received too many x-rays or inappropriate x-rays or MRIs. So I can see a constellation of measures centered around this lower back pain chronic disease.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Yes.

David Blumenthal – Department of HHS – National Coordinator for Health IT
This is David Blumenthal. I think there are three or four ideas that I think might guide us in the short term. First, are we committed to getting a couple of patient engagement measures into stage two of Meaningful Use, keeping in mind that there can't be 25 of them? Secondly, if they are, they have to be measures

that either have enormous face validity or have been well tested and established as valid measures of one or more of these concepts. Third, we can talk about further measure development for stage three, and that's important to do, but the key thing will be making sure that we honor a commitment to making more concrete the involvement of patients and their families in informing their care in stage two. When we do incorporate measures they can be measures that help patients or measures that help physicians, or both. That is, to Jon White's point, I don't think it's only measures that are useful to doctors or nurses or hospitals that we are looking after, we could also be creating measures that are useful to patients who are choosing among physicians. So I guess I do want to focus on the need to prepare to make some choices, or if we don't think there's any measure that's ready for primetime to defer it. But we're going to have to move fairly quickly from the concept to the practical, and then we're going to need some reason for adopting the measures, something that's clearly legitimate and valid.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, David. Other comments about this battery?

Christine Bechtel – National Partnership for Women & Families – VP
David, it's Christine. I agree with everything that Dr. Blumenthal just said and I understand Jon's comment and I agree. I think I just want to flag as an FYI that I think the challenge we will run into here is the culture around how we view certain measures, and I think measures of patient and family engagement historically have been measured that haven't been viewed as particularly valuable by the medical side, if you will, but yet if you ask patients and families what matters to them this is actually the stuff that really matters. So the link between some of these pieces like patient experience and improving outcomes is really strong for patients and families when you ask them. But I think some of the clinical community tends to write those kinds of measures off because they view them as oh, this is just a satisfaction thing and they don't see the direct link to clinical care even though it is there. So I just want to say, I absolutely agree with everybody, but I want to make sure that as we go through the patient and family stuff that we are cognizant of the kind of predominant cultural views of some of these measures.

Peter Basch – MedStar Health – Medical Director
Christine, this is Peter. I agree with you completely on that. I think part of the problem is the language that has been used historically in talking about patient experience, that term in particular, patient activation even more so, are terms that might initially make many physicians roll their eyes, that's too hard, what are we talking about here. But when we think about how we present and message these to clinicians, I believe there are ways to do it, and I think Paul Tang spoke about this and maybe some other people as well, where there's always clear medical evidence that engaged patients, informed patients, and patients who take, in a sense, ownership, and this is where I was getting at before about chronic illnesses, are patients who do better in the long run. So I think there is a way to bridge that gap and I think part of our work will be to come to a lexicon that we can all agree on that is accepted by the provider side and the patient side, and acts to improve care.

Christine Bechtel – National Partnership for Women & Families – VP
Thanks, Peter. I think that's a fair comment. I agree that Paul's, again, genius lumping, our favorite lumper, is a good one.

David Lansky – Pacific Business Group on Health – President & CEO
We want to move on to the next category. Let me just see if there are any major ideas or concerns that people want to voice at this stage of the process, guidance to the Tiger Team and the Policy Committee.

Ahmed Calvo – DHHS/HRSA – Senior Medical Officer
This is Ahmed Calvo. I think the one addition I would add is that we need to conceptually be really clear on whether we're talking about Meaningful Use mainly to the clinicians at the clinical level. The conversation to the patient level is one piece, but it's also a third level that we need to think about and that's the public health with community outcomes piece of it. Unless we think about all three up front I think we're going to be using a taxonomy that's going to have to be addressed again later. So I would encourage us to at least talk about all three levels, the patient level, the clinical level, and the community level so that we can get into the mindset of personal health records, electronic health records at the clinic

level, and community health records at the public health aspect so that we can get that meaning across to people as to why the population health outcomes become affected by these kinds of measures, regardless of which ones we choose first ..., but at least we should be able to see the framework bigger.

Bob Kocher – McKinsey & Company – Associate Principal
Hi, it's Bob Kocher for joining. I apologize for being late.

David Lansky – Pacific Business Group on Health – President & CEO
Hi, Bob. Did you want to get in the conversation?

Bob Kocher – McKinsey & Company – Associate Principal
I just joined so I don't know yet what I want to say.

David Lansky – Pacific Business Group on Health – President & CEO
Welcome. Last chance on this .... Any last comments or feedback you want to give at this stage?

Lewis Kasasaw
David, this is Lewis Kasasaw. I also joined late. I apologize. But I'm on now.

David Lansky – Pacific Business Group on Health – President & CEO
Glad to have you. Okay, then let's go to the next area. I'm sure we'll be back on this territory again. Clinical appropriateness, I think, Tom, are you going to take us through this one?

Tom Sang – ONC
Yes. So again I want to reiterate what Dr. Blumenthal had said, in that unfortunately we don't have the luxury of having all the time for stage two development. Just spanning from all the many suggestions we've had for clinical appropriateness, we see roughly over 260 measures, and you can see from the slide we've had 147 unique measures, so for stage two we really need to have measures that are somewhat specified around the late fall of 2011, to really coincide with the NPRM for stage two. So we need to do this really within six to seven months. So that really, I think, changes a lot of how we're going to view in terms of talking measures for state of readiness. So with that said, we received a lot of interesting measures and it was really hard to pare down, so I went from 147 to about 26 measures. In terms of the key concepts that had overwhelming response as a radiology overuse and underuse measures, the remissions measures where many, many organizations, partners, Kaiser, etc., had a lot of positive feedback. There was an interesting measure, as I mentioned before, in terms of looking at clinical quality dashboards and really creating a consortium of measures for a particular chronic illness like diabetes or AMIs or even congestive heart failure. There are some interesting measures looking at depression care coordination, so I think out of all the measures I just want to highlight a few of them, in particular.

First and foremost is the radiology overuse and underuse measures, looking at particularly the CT scans of the chest, the double scans and whether patients are having a chest CT ordered separately from an abdominal CT, whereas that could be done in a combination. Or even patients who had follow up mammograms and ultrasounds within 45 days after screening mammogram and a low enough number may mean that there's not enough follow up, whereas, a number that's too high may mean that it's unnecessary follow up. Out of the 113 retooled measures, specialty measures that we have so far, we only have one measure on lower back pain and that's looking at x-rays regarding radiologic overuse. So I think if we really hone in on this area there are pretty good suggestions here, and I just listed two.

The second thing is looking at medication link to adherence outcomes and also appropriate clinical care, and that would be in the area of preventing heart disease and specifically looking at lipid control. One of the things that all of us have been thinking of, and this would be in concert with many federal programs, would be looking at lipid control according to the Framingham risk scale. So, for example, patients who have two or more risk factors, do they have LDLs less than 160, so I don't have the Framingham risk score on the top of my head, but I think that would be one overall population health and clinical appropriate measure that would be certainly applicable to a wide spectrum of primary care doctors.

Then the third area is really in the area of readmissions. We have some measures right now in the retooled set looking at readmissions. But we've had an overwhelming response in terms of looking at all cause readjusted admissions as well as for three areas: pneumonia, heart failure, and acute MI. I think we have to look at how the claims data are translated into an EHR measure.

Then I would say the fourth area that was novel was preventable ED visits. Similar to preventable ambulatory care visits, one suggestion was looking at emergency room visits, which I think would be much more of a developmental, aspirational measure.

So those are the four or five key priority areas that I thought would fit the HIT sensitivity criteria, the parsimonious criteria, and then I think we can further discuss this in the Tiger Team session, Bob. I want to go over some of the gap areas. As I said before, many of the measures that were nominated were quite aspirational in terms of their developmental stage and then some of the methodologic issues I've highlighted for about a quality dashboard using multiple data sources across settings, that would be something that we need to figure out. The lipid control measure that's using the Framingham risk score, I was actually trying to calculate a risk algorithm using data extracted from EHR. I don't think we have any measures that are currently doing that, at least from the retooled measure sets. Then if we are deciding on some medication adherence measures, that's going to require some outside data sources such as pharmacy benefit plans looking at claims data. But overall I think it was a really very informative process and they're quite aligned with the concepts that were nominated by the Tiger Team.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Tom. Let me just ask you, given that you've identified the aspirational ... of some of these and the methodologies that are making them aspirational, flipping that, what would you say are the most likely to succeed to stage two ones that you saw in this group?

Tom Sang – ONC
I would say that the radiology overuse and underuse measures that I listed and perhaps the lipid control, we may be able to do that for stage two.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks. I'm going to open it up for discussion for anybody. Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Tom, I agree with you on the imaging and the lipid. I like the addition of the use of the calculated Framingham risk based on EHR data. That's a really nice way of incorporating EHR into the Meaningful Use criteria. Why did you not include readmissions as one you think that we're ready for and the other one particularly appealing so you can be in the care coordination ... care preventable admissions? Did you leave them out because you didn't think they were ready, or were there other reasons?

Tom Sang – ONC
We actually have a retooled measure on the All Cause Readmission Index that's risk adjusted for non-maternity and non-pediatric charges. I think the other was really for the congestive heart failure and pneumonia. I think there's an issue with the risk adjustment and also there just seems to be, we have to look at it. I just don't think it's primetime for stage two mainly because of, it seems like every single subject matter expert that I've spoken to, they are all saying that you need to incorporate claims data into that. I just haven't gotten my head wrapped around how we can do that in a short time frame.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
But aren't most claims data, well at least when you do have an EHR or derived from EHR, so in a sense even though it's not the final system that submits or exports the claim, the data that's used to generate it is in EHR? And this might be an offline thing. Just the niceness of having this be both clinical appropriateness and care coordination is what's appealing, the two-fer thing.

David Lansky – Pacific Business Group on Health – President & CEO

Paul, this is David. I have a question to everybody about that, a naïve question. Is it generally true that the EHRs are capturing member identification and prescriber information from the insurance plan that facilitates linkage if we're able to construct measures that require linkage?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I guess it would depend on what systems you have in place, obviously. Certainly the bigger health systems do have one where the diagnoses are fed from the clinical system into the financial, so those claims data would be in the EHR as well. That may not be an across the board –

David Lansky – Pacific Business Group on Health – President & CEO
Maybe Jacob or someone knows, in an ambulatory EHR, I'm just wondering, like the e-mail example in the previous category, is there an opportunity here to make sure that EHRs are capturing the kind of information needed to facilitate linkage to third party claims data if we want to do longitudinal record construction?

Timothy Ferris – Massachusetts General – Medical Director
Tim Ferris. I think we're way far away from that in general. We do it here, but it's taken us years to get there. I don't think we can expect that that would be from regularly collected field or that the data connections would be something that we would expect in the near one to two year timeframe.

Jacob Reider – Allscripts – Chief Medical Informatics Officer
This is Jacob. I would agree. It's a mapping vocabulary issue that many of us on the call are familiar with, non-trivial.

David Blumenthal – Department of HHS – National Coordinator for Health IT
This is David Blumenthal. It presumes a level of interoperability within a community that I don't think we will have achieved in stage two, especially if you're talking about administrative and clinical data merging into a single stream and being universally available. So I think it's going to exceed the capacity and probably exceed, you never know, I can't say exactly what stage two will require in the way of exchange, but I don't think it will require that a given physician be able to access all the records on a patient within a community. And in order for you to know who's been readmitted, you need to be able to access the claims and/or clinical records for all the hospitals in your community or within the geographic area that the patient is likely to be hospitalized in.

Jacob Reider – Allscripts – Chief Medical Informatics Officer
There's also a timing issue too, even if one could do that, because I typically think of claims data not as what we submit as claims, but what the payers' process as claims. And there can be an issue of poor timeliness in terms of getting that data, at least that's what we've experienced when we've tried to do it.

David Blumenthal – Department of HHS – National Coordinator for Health IT
If you had good connectivity you wouldn't need claims data, you would just know that a patient had been seen in the emergency department and/or admitted to a hospital and you could do a query about, or if the automatic uploads of data about when certain patients were admitted to any place in your community. But we don't have that ability right now. It would be nice if we had it in stage two, but I don't think we will.

Jacob Reider – Allscripts – Chief Medical Informatics Officer
Yes, that to me is more aspirational than incorporation of administrative and clinical data. I think it's a great idea, but we're nowhere near that yet.

Tom Sang – ONC
I would back at an even more primitive level of just wondering if the identifiers are captured to permit a third party to do the linking, whether it's an HIE or a measurement vendor or whoever. But I guess what I'm hearing from this has really raised an important concern and maybe it launches something, either a methodology discussion or the IE Workgroup can look at it. But many of the areas of interest of care coordination and appropriateness are going to require some kind of cross-setting data linkage, and if we think it's really three years out or five years out or what the trajectory is, are there incremental things we

should be doing now, either in data capture at the EHR, or in infrastructure at the HIE, just to answer these questions in a reasonable time frame.

David Lansky – Pacific Business Group on Health – President & CEO
The policy issue here is if you require that it be measured, in order to be a meaningful user you create an incentive to make it happen. So if you want to push for interoperability in exchange faster, you can make it essential to Meaningful Use. But you have to be extremely cautious and titrate such demands against the ability of the system to accommodate them.

Tom Sang – ONC
Understood. So I guess I'll go back to Tom and suggest as ONC goes further with this set of issues and these measures that you've recommended for consideration, we may need to commission someone to do some work on a glide path that's realistic, given David's caution. I think we all want to see this field move forward, but we see a pretty fundamental data availability problem.

Peter Basch – MedStar Health – Medical Director
This is Peter. I have one other question on this. On the slides you have usage rates for generic versus brand name medications. You didn't mention that as something that you felt was high on the priority list. Can you comment on that a bit?

Tom Sang – ONC
The suggestions that we received weren't very specific. There are no measures actually that was recommended and they're all conceptual in nature. The other thing is that it does require another source of data, at least whether the patient has, at the point of service of filling out the prescription from the pharmacist, I think they would need to gather another source of data as they're filling it out, and I think that's where the problem is. So we're not quite there yet.

M
I would agree, and I think we're not quite there for other reasons as well, including the fact that due to the nature of safe prescribing laws that if we were measuring usage rates of creating prescriptions for generic versus brand name, that may be a different reality than dispensing of generic versus brand name, because depending on how prescriptions are written for particular states, you can have a prescription written for a generic that is filled with a brand name. We have a "Brand name necessary" or "Dispense as written" for protecting brand name requests. I don't believe, at least not in the states that I've practiced in, that we have a code that says "Must give generic." There's a lot of pharmacist's discretion. So I think this would be something to think about for stage three, but I think we would need to also involve the pharmacy community in getting more information about this before we could make it real.

David Lansky – Pacific Business Group on Health – President & CEO
It sounds to me like there are a couple of measures that people found the most interesting. One is related to radiology overuse and underuse. A third was related to lipid control. And there are a series of other measures that need to be further assessed as possible stage later measures. The question is whether there are some other measures that are possible candidates for stage two. I guess as we go forward we should try to add a couple, because keep in mind that all these measures will be subject to comment. If they're chosen for stage two they'll go into an NPRM. The NPRM will then be commented on by the large community and it's unlikely that more measures will be added after the NPRM. And it's also possible to put in measures that you think are pretty good but not quite ready simply to elicit comment about whether they are interesting and how to perfect them.

Tom Sang – ONC
I just want to note to the group that there were really quite good measures regarding medication overuse and underuse, but Leah will actually be talking on a couple of them and they mainly revolve around potentially harmful drug disease interactions in the elderly, inappropriate medications for the elderly, and high risk medications in the elderly.

Neil Calman – Institute for Family Health – President & Cofounder

This is Neil Calman. I just wanted to tell you that I've joined the call. My board meeting just ended.

David Lansky – Pacific Business Group on Health – President & CEO
Hi, Neil. Let me try to wrap up this category now Are there any further suggestions or guidance people want to share with the Tiger Team on how to navigate this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In the spirit of what Peter Basch talked about in terms of generic versus brand, but not focusing on usage, which does require that additional pharmacy data, but on prescribing patterns, it's not unlike I suspect the diagnostic imaging procedure orders, where you are doing in some sense a comparison between procedures for a given indication. Similarly, the way the Meaningful Use Workgroup originally proposed stage one talked about the use of generic medications when they exist and have an evidence-based efficacy and effectiveness in that class. So there's an area that may be useful and of course it's the two-fer in efficiency, so in the spirit of what David Blumenthal said of can you propose something and get public comment on it, that's another area where you could have a big payoff. This is for your consideration in terms of what might go in there.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Paul. Any other last suggestions? If not, we'll move on to care coordination. Tom, I don't recall who's going to walk us through this one.

Tom Sang – ONC
Cray.

David Lansky – Pacific Business Group on Health – President & CEO
Welcome back, Cray.

Cray Noltert – ONC
It's good to be back. Thank you. So you guys will note that in care coordination there were 20 unique responses, which provided 71 unique measures that were ultimately submitted. I'm pretty optimistic about the level of measures that were submitted. In general, I think that the measures seem to be reflective of what the Care Coordination Tiger Team had discussed on their calls. I wanted to highlight a couple of different areas here in the measure concepts and highlight a couple of different examples for each. Within Comprehensive Care plan you'll see that predominantly the responses were either very aspirational here or were asking us to define the exact comprehensive ... and so those measures you'll see we only selected one of which. As far as the Advanced Care plan, we did receive numerous measures on this and we selected a few, one of which, as a highlight example, is more than 30% of unique patients of the eligible provider have a documented Advanced Care plan in place. This would actually build off of the stage one Meaningful Use existing measure.

We have the third line down there, measures dealing with the adherence to and success of self-management plans, and here actually the Care Coordination team had talked a lot about various different self-management plans, and actually Tim Ferris is on the phone and maybe can describe more about that. The specific measures we received were rather optimistic about the use of self-management plans, and I'll highlight one specifically, which is diabetic education and training. I felt that that measure was pretty reflective of what the Care Coordination Tiger Team had talked about and reflective of public comment. To broaden it out a little bit, we did have some measures that were submitted, one measure in particular looking at the self-management plans for chronic care for specific disease populations, which I thought was another interesting measure.

Regarding measures for medication reconciliation the majority of measures in this category were actually already being retooled for stage one, they were proposed in RFC, measures the patient and family experience of care coordination in which you all had already talked about it earlier on the call, are really in line with what we had talked about in the Care Coordination team. The one measure that I would like to highlight to the group that was submitted a few times was the Eric Coleman Care Transitions measure

three item survey, NQF number 228, and I feel that that one may actually also be ready for stage two and more likely stage three development.

Looking towards composite measures as received by both care team members and the patient and caregiver, in this category we were hoping to see more, as Tom was mentioning before, of measures that had variables of composite measures embedded within them. Unfortunately we didn't really see that from RFC measures. At the same time I will note that there are two specific measures. The first that I'd like to highlight is actually one that was submitted at the NCQA and it refers to the primary care physicians when they're referring to the specialist in terms of closing the referral leads.

There were a number of comments on the assessing the timeliness of provider response and appropriate response of clinical information. These measures also actually overlap with Tom's domain of appropriateness, and I'm just looking for my specific spot here. So the majority of measures that were actually submitted for appropriate response in this category were very specific and not as parsimonious. There were a few that involved ... conditions, such as HIV and age, that I thought were rather unique and should definitely be turned around quickly for stage two development.

So that is my initial feedback for the group as far as the measure concepts are concerned. I'm happy to take questions at this time, or I can move on to the next slide and discuss the gaps of methodologic issues.

Peter Basch – MedStar Health – Medical Director
This is Peter. I have one question on the measures for advanced care plans. If I heard you correctly, did you say the proposed measure was achieving 30% of patients seen during a measure year who have an advanced care form in the EHR?

Cray Noltert – ONC
The measure is "more than 30% of the unique patients of the eligible provider have a documented advanced care plan."

Peter Basch – MedStar Health – Medical Director
This is restricted to particular ages?

Cray Noltert – ONC
No. We were trying to get away from some of the measures that were specifically related to a 65 and older crowd, and we actually received a number of different measures that related to all ages. And so for this specific measure it's not necessarily age dependent.

Peter Basch – MedStar Health – Medical Director
Okay.

David Lansky – Pacific Business Group on Health – President & CEO
Cray, I don't remember, does that measure contain the shared decision input?

Cray Noltert – ONC
It does, yes.

David Lansky – Pacific Business Group on Health – President & CEO
Does that require patient reported data?

Cray Noltert – ONC
Yes, it does.

M
You're not looking for specific comments at this point, right?

David Lansky – Pacific Business Group on Health – President & CEO
Cray, why don't you go ahead and finish the next slide and go through the gaps and so on, and then let's have a general discussion about this array?

Cray Noltert – ONC
Perfect. Some of the gaps that we found, first and foremost were within the comprehensive clinical summary. We recognized that the Meaningful Use Workgroup is actually working on some of the elements of clinical summary. Most of the gap ... here that we're outlining relate to the feedback in terms of the defining elements of the clinical summary. The second gap area is the idea that we should be closing the referral loop specifically in the outpatient setting when primary care providers are sending the patients to specialists and ensuring that there are tests and feedback is getting brought back in to the PCP's purview.

The third area here is measures related to action plans, which we discussed a little bit about, and the ability to have an action plan in place for patients. Interestingly, there were a couple of comments related to the action plans that stated that the ONC should try to progress in terms of action plans that are outside of chronic care conditions, but unfortunately they didn't provide any specific example of the measure that they would provide.

As far as methodologic issues are concerned, there's difficulty in measuring clinical summaries from various settings ... care, and that data verifying care coordination has occurred. So in this second bullet point we're saying that we want to make sure, an example I just used is information flowing to and from a primary care provider to a specialist and back, or vice versa, and we had verification that data has been bidirectional in that case.

Finally, standardization of a longitudinal record or an action plan for patients. This is something that was brought up in the ... report before and we think that this going forward will be a methodologic issue for stage two and stage three.

David Lansky – Pacific Business Group on Health – President & CEO
Let me ask the same question because I think you said it but ... it, what would you say for stage two are the most likely to succeed that you'd encourage ONC to give earliest attention to?

Cray Noltert – ONC
So for stage two I think that the first measure concept that I'd look at is the self-management plan measure concept. That's the diabetic self-management education training measure that I specifically outlined, but there's a few others that the Care Coordination team can talk about. Then the other area that did receive high public feedback would probably be the advanced care plan as a product of shared decision making building on stage one Meaningful Use measures.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks. So, general discussion?

M
Was the public comment about the advanced care plan positive, favorable?

Cray Noltert – ONC
Yes.

M
Then the other question is, you mentioned a percent of 30% and what we had in the stage two proposal was 50%, any specific comments about that, not to get too detailed?

Cray Noltert – ONC
Sure. I think that that's an area that I think that I'll let you all debate as far as 30% versus 50%. That was the specific measure that was submitted. Regarding positive and negative feedback on this specific

measure concept of advanced care plans, in general I had to say that all of them were very positive. I didn't actually come across any that were negative. The only area that was a little bit up for argument was exactly what should be included within the advanced care document itself. Was there documentation of the plan and if they didn't ask then documenting that or if it's not applicable documenting that, and then also the physician medical orders for ... treatments. So that was the only maybe small issue in terms of differences between the comments, but overall they were pretty positive.

Timothy Ferris – Massachusetts General – Medical Director
This is Tim. I'd maybe make two comments about this, and thank you, Cray, for going through it. One of them is that I'm impressed with the extent to which this exercise will hopefully focus people's attention on the need for more rapid focus and attention on the development of measures in this area. I know it's sort of disappointing to look at the ratio of mini ideas to things that ready is not great in terms of stage two, but it seems to me that it does hopefully bode well for the future.

The second thing that came up in our Tiger Team was this issue of a lot of people talked about the fact that the content of specific care coordination plans and plans are heavily discussed in a lot of these measures, and the extent to which a measure that's potentially stage two needs to actually do a lot of work defining what's in that plan. And the reason why I say it is there are a couple of schools of thought about this, but one could imagine just saying leaving it relatively open about what's in the plan and seeing what happens with the development of this. Of course, one might look at that and say well, they can just do anything and it wouldn't be meaningful, but doing anything would be a lot more than what's going on in general in practice right now. So you can look at this as an exercise in rapidly defining what should be in the plan or you can look at it as more of a market-based approach and say we're going to make this a requirement. We're actually not going to specify to the extraordinary detail what's in one of these plans, but let the market decide and then later on, in a further round, tighten up on the definition. And I just wanted to put that out as attention to be thought about in the further working of these measures related to care coordination.

David Blumenthal – Department of HHS – National Coordinator for Health IT
This is David Blumenthal. As I look at these measures, and I share Tim's summary of the state of the field in care coordination, there are other areas where we come away somewhat disappointed and look at the types of measures, and this is clearly one of them, especially since it so much goes to the heart of what electronic systems are supposed to be able to do that paper can't. It makes me wonder whether we need a glide path on this dimension of quality that emphasizes capacity in stage two and delivery on the capacity in stage three. What I mean by that is, to take us back to the conversation we had before about the admissions and the role of Meaningful Use in creating demand for a type of measure and a type of service that otherwise wouldn't materialize. To a large extent whatever we require in the way of Health Information Exchange will be a necessity for and a facilitator of care coordination. So just knowing simple things like having in your record the electronic version of a referral note from a specialist to whom you've referred, knowing what lab tests have been ordered by other physicians, just sort of basic measures of knowledge, medication reconciliation is in the nature of that. But it could go to many other dimensions and until we have pretty good exchange a lot of these we're not going to be able to hold individual providers accountable for having that kind of information. And yet if we don't ask for exchange and hold people accountable, the capacity won't develop as fast.

So there's an important way in which the exchange requirements of stage two are a care coordination measure, or at least on the pathway in stage two toward a set of measures that will take shape in stage three. I don't know to what extent, Paul, in the Meaningful Use Workgroup, this particular issue came up and whether there are others who have comments on it. What I'm saying in effect is what we're posing here is the question of how much exchange information should we require in stage two? That is the foundation of almost all the care coordination we want to accomplish.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is Paul. This is definitely an area that we wanted to encourage, a request from you to encourage was somewhat thwarted by the state of where exchange is right now. But clearly, as you point out, we'd love to motivate it by the true clinical need, instead of saying, well, you must exchange with care

coordination, which is probably on the top of the patient's experienced need. If you look at the surveys, what do patients want us to do? They want us to care about them, they want us to know things about them, and they're most frustrated by when we don't know that or take that information into account. So that may be one of the strongest ways to deliver too, to motivate the exchanges, is care coordination. And then of course hospitals have a very vested interest with respect to readmission, that's already coming into payment.

M
I will say, David, the Information Exchange Workgroup is also having this conversation actually right now I ... dialogue, trialogue between the Meaningful Use group, these quality measures and the information exchange process will be fruitful to try and get agreement about how much we can pull with the stage two requirements.

David Lansky – Pacific Business Group on Health – President & CEO
One way to think about this is to say what do want to be capable of in 2015 and what do we have to be able to do in 2013 to get to 2015?

M
I think that might be very informative for what we choose to measure as an indicator care coordination in 2013 and in 2015.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
This is Karen Kmetik. Let me just offer another thought. While we're on the glide path to adding the functionality for the exchange of information, is there a place in the more short term to build on some existing Meaningful Use stage one measures and add to them some pieces of action plan, if you will, that does not necessarily require exchange of information? I know this doesn't get us where we want to, but in the spirit of moving in the direction, for example, we start with the blood pressure was taken and the blood pressure was recorded in the EHR, and we want to move that toward is the blood pressure at goal? And if not, why not? So, we could begin to add a stratification of the blood pressures and what are the plans for those not at goal. I'm just thinking out loud about some step wide progression.

David Lansky – Pacific Business Group on Health – President & CEO
I think that's a great measure. I'm not sure it constitutes a care coordination measure.

Eva Powell – National Partnership for Women & Families – Director IT
This is Eva. I wanted to piggyback a little bit on what Karen just said, in the sense that I think we're thinking along the same lines, but there's more to information exchange than Information exchange between providers across electronic means, which obviously is what we're after ultimately. But I think to the degree we can encourage information exchange internally by pulling key pieces of information together in one place, that constitutes information exchange that isn't currently happening in the sense that that information may be recorded and available in various places, but because it's scattered throughout paper records it's in essence not exchange, if that makes sense. So what I'm thinking in terms of a care plan and ultimately working toward a longitudinal share plan, that obviously involves a lot of the exchange capabilities and we don't have ... a lot of standards, but we still need to work towards perhaps an intermediate step. It could be something along the lines of doing what I think Tim mentioned before, is requiring the action of pulling together certain pieces of information within a rudimentary care plan and perhaps leave that somewhat open, although I would advocate, we could probably agree on some pretty basic requirements that in order for it to be considered a care plan of any sort, that you would need to have certain pieces of information and then start requiring that as part of Meaningful Use. And because of the capacity that the electronic health record has to record items in ... fields and then pull those things together in some sort of report format, that that might be an intermediate step to start pulling information together that is available but essentially unavailable because it's scattered throughout a paper record, if that makes sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This is Paul. If I can just comment on what we've put out for a request for comment in this particular area, care coordination. I think it ties into the previous two comments, and so one question is, are there quality measures that could be tied to these proposed criteria? So one is to just get connected, and what we suggested was to connect at least three external providers in your primary referral network. That's basically getting ... well, connect to your clinical training partners. The other piece is what Eva just mentioned, which is to record a longitudinal care plan for 20% of your patients with high priority health conditions. So focus on these particular key data elements and get them to the people who you do most of your business with, the clinical training partners. So that was our approach. And in a sense, following what Karen said, well, can you have some actions that are going to produce value and at least a step in the right direction. So to the extent that there are quality measures that could help measure how you accomplish these, that would be great.

Carol Diamond – Markle Foundation – Managing Director Healthcare Program
This is Carol Diamond. I just want to say that I've been listening to this conversation about readiness for connectivity and the capacity to exchange electronically, and I guess I would just point out that there will always be asymmetry in training partners. There will always be the case where one may be ready and the other is not, and that for all of these goals, particularly in care coordination, I think it's very important that an option to fulfill some of these transfers is available through the patient.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Carol. I am mindful of our time and I guess I'd ask if there are any last words on this subject and then we should go to the patient safety category and try to get a few minutes in on the last two categories before we have to wrap up. Any last words on this one?

Josh Seidman – ONC
This is Josh. Just one other quick comment on the methodological issues. There obviously are a number of measures here that require patient reporting data, so to David Lansky's earlier comment about having some methodological work specifically done on that issue, we would obviously want to incorporate that care coordination into that work.

Eva Powell – National Partnership for Women & Families – Director IT
This is Eva. Just one quick comment based on what Carol just said. The requirement, the definitive draft of the care team members and recording the care team members, that's a major way that we can incorporate or pull the patient into this whole process, and it also assigns accountability, it takes a step toward assigning accountability, in other words, that is going to be necessary for the care plan as well. So that is an element that links up, I think, pretty closely with that whole function.

Neil Calman – Institute for Family Health – President & Cofounder
This is Neil. One additional thought, which is if we're looking for kinds of measures that could potentially be used that don't necessarily require the electronic connectivity right now, we can think of .... And also I'm thinking about the fact that people keep saying we need more specialty measures, something that we can look at in terms of care coordination and it should be pretty easy to document an electronic health record for specialists would be the time from when there's a specialty visit that's made on referral to the time when there's some documentation of a report that's sent back to the primary care provider. And that kind of care ..., that's just an example of one kind of measure that one could develop that doesn't necessarily require that that report go back electronically, but still would document the care coordination.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Neil. That's interesting. Let's see if we can move on because our time's getting short and go to the patient safety category. Thanks, Cray, for all that guidance. And is Leah going to talk about this, Tom, or someone else?

Tom Sang – ONC

Yes, Leah.

Leah Marcotte – ONC
So for patient safety we received over 100 comments, 65 unique measures. Some general comments asked that there be alignment with the National Healthcare Safety Network, especially with respect to hospital acquired infections and with the National Quality strategy. The suggestions overall were very reflective of the Tiger Team conversations and measure concepts. Specifically, there were a lot of measures that had already been retooled and will likely be included in stage two. Additionally, there were some measures that weren't included in the measure concepts, such as pressure ulcers, which received three to four measure suggestions.

Some of the key priority areas were adverse drug events, AHRQ common format was adjusted to help develop measures surrounding adverse drug events. Monitoring patients on persistent medications, Kaiser suggested using the NCQA measures that monitor patients on Warfarin, antiepileptics, diuretics, and Digoxin. Another measure priority was adverse effects of medications in the elderly, and Kaiser also suggested the NCQA measure of drug disease interactions in the elderly in addition to the already retooled inappropriate medications in the elderly.

Falls risk assessment and outcomes was also a priority area, VTE, VTE prophylaxis, and healthcare associated infections. Of note, a lot of the healthcare associated infection measures have already been retooled, as well as VTE prophylaxis for perioperative patients.

Some of the gap areas that fall within adverse drug events and falls particularly and capturing data with respect to adverse drug events, how you define adverse drug events, and capture that data in a meaningful way.

In addition, cross-cutting measures that capture ... healthcare patient ... measures and hospital and ambulatory settings, which was relevant for both adverse drug events and falls prevention and outcomes, and then measures requiring risk adjustment, particularly for falls outcomes.

Stage two priorities would probably fall under mostly the adverse drug events medication related measures, as well as all the measures I mentioned that are already retooled. In stage three, falls outcomes was difficult, as mentioned, because of risk adjustment issues. And the patient identification error is also something that could be considered for stage three and was pointed out by the AMA.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Leah. Thanks for summarizing the takeaways. On adverse drug events I heard two messages. One is everybody thinks it's really important and a lot of people wanted to comment on it, and on the one hand it's ready for stage two because it's of such clinical importance and visibility. On the other hand, you're saying there's some methodology problems that are tricky here. What's your takeaway from what you've seen on the comments about our ability to get adverse drug events into stage two? What work has to be done, do you think?

Leah Marcotte – ONC
Unfortunately with adverse drug events with these comments there weren't too many specific measures that were suggested and not too many specific measures that could be retooled. There are some adverse drug events outcomes measures regarding specific medications, but they're not retooled. It's going to be very difficult, but it could be potentially a high priority area that we could push development for stage two. But it's definitely a concern and will be difficult.

Neil Calman – Institute for Family Health – President & Cofounder
This is Neil. One of the things that came up the most in this discussion is how these rates could vary tremendously in different types of practice settings, so that it would be hard to benchmark them or say either what's the right number of adverse drug events that one would expect to be reported on, and also if

we're really looking to say these are quality measures, are people reporting more of these doing better quality or doing worse quality care. The other thing was that I think to call out for the future, there was a real need in the adverse drug reporting area, people thinking about drug disease, drug lab, drug pregnancy, and drug lactation, there's all kinds of things where what's needed is a sort of generally accepted list of those kinds of medications like we have for the elderly that can potentially be used. Those might actually be easier to develop some benchmarks around in terms of use and what would be appropriate.

David Lansky – Pacific Business Group on Health – President & CEO
Some additional discussion about this whole area and where ONC should go forward in the next few months?

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice
This is Tripp Bradd. I'd like to hear a little bit more about the patient identification thing, which as we talked about in the Tiger Team, was the basis for a lot of the other adverse safety events that occurred. What were the comments regarding the AMA and how that might become a fairly easy measure with regard to identifying patients, whether it be notification of a picture taken or something that might be able to help in that realm.

David Lansky – Pacific Business Group on Health – President & CEO
Leah, can you say any more about what you got?

Leah Marcotte – ONC
Yes. There weren't any specific measures, it was just that patient identification errors, there should be a measure developed. And I believe that Art suggested that they could use the common format to help with that measure.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice
Okay.

David Lansky – Pacific Business Group on Health – President & CEO
Other comments about this area? All right, we will refer it back to the committee. Thanks, Leah, for taking us through that. And let's go on to the population and public health one.

Lanre Akintujoye – ONC
Hello, this is Lanre. Given our limited time I'll try to move fairly briskly through this. We had 18 unique responses for the population and public health domain area, with 73 unique measures recommended. In going through the responses, the three main kinds of areas of interest for us were the body mass index measure concepts, the blood pressure measure concepts, and the glucose monitoring measure concepts. In terms of the responses, given that the body mass index measure concept was focused specifically on tracking longitudinal change, we did find that a lot of the measures were either aspirational or did not necessarily address the longitudinal delta measure aspect of the measure. So more specifically and looking at some of the responses, there were some recommendations that addressed the measure concept. There was one from the California Primary Care Association in which they recommended a BMI improvement in which patients would reduce focus on patients with reduced BMI out of patients with a BMI greater than 25, and that was for adults. But again that was an aspirational measure.

In terms of the blood pressure measures, again, focus on the delta measures, focus specifically on determining patient outcome. There were some recommended measures and these were also aspirational, as were some of the glucose monitoring measures. The measures that weren't aspirational that were recommended, a lot of them fell within the list of measures currently being retooled by the NQF. But those didn't necessarily address them as ... concepts determined by the Tiger Team.
For the blood pressure measure concept, one measure of interest was the patients with focus on hypertensive patients, and it was the patients with two or more blood pressures greater than a certain amount whose BP was already controlled, and Tom is going to speak more specifically to this measure.

Tom Sang – ONC
Yes. One of the retooled measures that we have is actually NQF number 18, that's the percentage of patients 18-85 years of age who had a diagnosis of hypertension already and whose blood pressure was adequately controlled during the measurement year. But I think what we all know, or there's been a large amount of evidence that's actually been published from the Geisinger folks, who looked internally and saw that there's a huge swath of patients within their own system that didn't have a diagnosis of hypertension on the problem list. So when the measure specifically has a specification of diagnose hypertension, you're going to miss a large portion of the population who by definition if they've had two or more blood pressures that meet the criteria, diastolic and systolic criteria, but yet really have been undiagnosed, I think we're going to miss this large percentage of population in terms of measuring whether their BPs are controlled or not. We are interested in looking at this one particular measurement which is using, again, an EHR algorithm and also looking at specific structured data fields of two or more blood pressures, rather than a diagnosis of hypertension.

Lanre Akintujoye – ONC
Moving to the next slide –

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Can I ask for one clarification on this slide?

Lanre Akintujoye – ONC
Yes.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
This is Fran Cotter, SAMHSA. Your reference to the behavioral health measures, screening for alcohol use and mental health screening, at least let me address those two. Did you reference that they are in the process of retooling now? Could you clarify what you meant about those two measures?

Lanre Akintujoye – ONC
There are a few measures that fall within that measure concept that are in the list of being retooled.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
I wanted to clarify that the key ones that the tag team put forward on screening and brief intervention for alcohol and follow up for mental health are not in the retooling list. But they are ready to go through consensus and there are funds available, but I just want to clarify that and maybe we can do it offline.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, that would be great, Fran. I think the ones that Lanre had mentioned specifically have to do with depression remission at 12 months, 6 months, and then –

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Those are considered specialty treatment measures once you're diagnosed, or they could be in primary care but there's a difference between the use of those measures for screening versus once diagnosed using it for symptoms, checking outcomes.

Lanre Akintujoye – ONC
Okay. Thank you for the clarification. Moving to the next slide, gap areas identified were primarily around the effective preventative services in the health equity area, and so these are just areas in which there were not necessarily as many comments submitted from the public as other sub domain areas. In terms of the methodological issues, one related primarily to the health equity measure concepts, in that there were some challenges in the information that would be of interest for this health equity measure concept. They're not necessarily structured data fields already created within the EHR capable of collecting some of this information. Another methodologic issue, population health management does present some challenges to traditional outcomes measures and this was seen primarily in us asking for longitudinal delta measures and there are not necessarily many measures that can address that issue. The same with the standard data entry conventions needing to be identified with some of these measures, and I

think that's primarily related to the whole methodological concept of delta measures we're trying to collect or measure changes in health outcomes.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks, Lanre. Let me ask one specific question before we have any more general discussion about the longitudinal measures like BMI and blood pressure. ... Neil or Jacob or Paul, what's the difficulty of constructing a measure, today there's already ... about a particular set of patients who meet ... criteria as of January 1st, and those patients are still effectively enrolled in December 31st. Is the difficulty methodological in finding the measure, or is it a data acquisition problem? What's the difficulty? Why is it aspirational, I guess is my question? It seems on the face of it not that hard.

Neil Calman – Institute for Family Health – President & Cofounder
I guess one aspect of it is there's nothing that guarantees that the patient's back in that second measurement time, so you can have somebody where you've got a BMI measurement in January and in April, but they don't come back again until the following April, and now you're looking at it at the end of the year, but you really only have two measures that are three months apart. So that is a real problem.

David Lansky – Pacific Business Group on Health – President & CEO
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
So you're doing a longitudinal look, but you don't really know where your second or third or fourth measure is. And that's really, as far as I know, that's really the major methodological difference. The other thing is that I don't think that should hold us up from looking at some of these. I think that if you have measures within a particular interval, even if it's a subset of the population, that would be good. I think the other thing is, you can also report on the extent to which you don't have follow up measures, which I think would get us back to this whole issue of how well people are doing without recent follow up of their patients.

David Lansky – Pacific Business Group on Health – President & CEO
... any other quick comments before we have to go to the – I don't know if Judy's on but I think we need to do public comment today?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes we do, David.

David Lansky – Pacific Business Group on Health – President & CEO
Okay, so we'll do a couple of more comments and then we'll try to wrap this up.

M
I want to reiterate in general that it would be great if each of those teams came up with two, three, four stage two measures and two, three, four aspirational measures and the activities that are needed to get both sets of measures ready to move into a more formal public comment. And on the point that Neil just made, by defining a quality measure that's longitudinal, you define a pattern of care that's expected. So if somebody has an elevated blood pressure, they should have another blood pressure within a year for sure, probably sooner than that. And if they don't, that's a quality problem. Now, you could argue that they have it measured somewhere else, but then the physician, or at least a primary care physician, should know what it was. So I think the methodological problem may be in – I'm not sure what the methodologic problem is. We're pretty good at figuring out how to measure blood pressure and we're pretty good at tracking it over time. So anyway, those are my comments before the public comments. Thanks.

M
Just one last quickie. But with blood pressure the methodologic issue is which value do you count? So somebody's blood pressure is going up and down during the course of the year and you're picking out a

particular interval and time to measure it, that was what we brought up in the discussion of that. But none of this should dissuade us from using these kinds of measures. I think they're great.

M
One more quick comment, David. Hopefully we won't design measures that would inhibit people from going outside of the office, so for example we're going to be doing online blood pressure readings at home and it would be a shame to qualify and get good measure scores and you'd have to actually bring people in, where we're trying to push the measures and surveillance to the home.

David Lansky – Pacific Business Group on Health – President & CEO
Thanks. All right, well let me just wrap up this part of our discussion. I think we've been extremely successful today and captured a lot of input on the first round, the first cut of these measures, and I think Dr. Blumenthal's last advice to us was exactly right, that Tiger Teams need to go off and pick a very small number of stage two ready and a small number of stage three likely and the steps to get them to that point of likely to be approved. And so that will give ONC guidance on what vetting and development work needs to get done in both categories over the next several months and perhaps a year or two. So that will be the charge to the Tiger Team, and I think by e-mail Tom and company will send out some instructions to us all and try to schedule some follow up meetings to drill down, and then as we get to March we'll have an opportunity to talk about some of these broader methodology questions that surfaced today.

So with that, let me just thank all of you for making the time to jump into the conversation in high speed and high precision both. That's really helpful. And, again, thanks to the staff for all their work getting us to this point. Judy, why don't you let us hear any public comments that there are?

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, could you please invite the public if anybody wishes to make a comment?

Operator
Yes. (Instructions given.) We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, operator. David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Thank you, Judy. Thank you, Dr. Blumenthal. Everyone, thanks for taking the time to join us today. We will be crunching all of this and circulate it back to you as soon as we can. We appreciate everyone's time and critique. Thanks very much.

David Blumenthal – Department of HHS – National Coordinator for Health IT
David, thank you so much.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

M
Have a good day.

David Lansky – Pacific Business Group on Health – President & CEO
Bye, everybody.